

		FOR OHF USE					

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2003
STATE OF ILLINOIS
DEPARTMENT OF PUBLIC AID
FINANCIAL AND STATISTICAL REPORT FOR
LONG-TERM CARE FACILITIES
(FISCAL YEAR 2003)

IMPORTANT NOTICE
 THIS AGENCY IS REQUESTING DISCLOSURE OF INFORMATION
 THAT IS NECESSARY TO ACCOMPLISH THE STATUTORY
 PURPOSE AS OUTLINED IN 210 ILCS 45/3-208. DISCLOSURE
 OF THIS INFORMATION IS MANDATORY. FAILURE TO PROVIDE
 ANY INFORMATION ON OR BEFORE THE DUE DATE WILL
 RESULT IN CESSATION OF PROGRAM PAYMENTS. THIS FORM
 HAS BEEN APPROVED BY THE FORMS MANAGEMENT CENTER.

I. IDPH Facility ID Number: <u>0021832</u>		II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER	
Facility Name: <u>Arthur Merkle Clara Knippprath Nursing Home</u>		I have examined the contents of the accompanying report to the State of Illinois, for the period from <u>7/1/03</u> to <u>12/31/03</u> and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.	
Address: <u>1190 East 2900 North Road</u> <u>Clifton</u> <u>60927-9705</u> <div style="display: flex; justify-content: space-between;"> Number City Zip Code </div>		Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.	
County: <u>Iroquois</u>		Officer or Administrator of Provider (Signed) _____ (Date) _____	
Telephone Number: <u>(815) 694-2306</u> Fax # <u>(815) 694-2818</u>		(Type or Print Name) <u>Brother Damien, OSF</u>	
IDPA ID Number: <u>362841358001</u>		(Title) <u>Executive Director</u>	
Date of Initial License for Current Owners: <u>10/15/75</u>		(Signed) <u>See accountant's report</u> (Date) _____	
Type of Ownership:		Paid Preparer (Print Name and Title) <u>Mark L Smith</u> <u>President</u>	
<input checked="" type="checkbox"/> VOLUNTARY, NON-PROFIT <input checked="" type="checkbox"/> Charitable Corp. <input type="checkbox"/> Trust IRS Exemption Code <u>501(c)(3)</u>		(Firm Name & Address) <u>Smith Koelling Dykstra & Ohm, PC</u> <u>1605 N Convent, Bourbonnais, IL</u>	
<input type="checkbox"/> PROPRIETARY <input type="checkbox"/> Individual <input type="checkbox"/> Partnership <input type="checkbox"/> Corporation <input type="checkbox"/> "Sub-S" Corp. <input type="checkbox"/> Limited Liability Co. <input type="checkbox"/> Trust <input type="checkbox"/> Other _____		(Telephone) <u>(815) 937-1997</u> Fax # <u>815-935-0360</u>	
<input type="checkbox"/> GOVERNMENTAL <input type="checkbox"/> State <input type="checkbox"/> County <input type="checkbox"/> Other _____		MAIL TO: OFFICE OF HEALTH FINANCE ILLINOIS DEPARTMENT OF PUBLIC AID 201 S. Grand Avenue East Springfield, IL 62763-0001 Phone # (217) 782-1630	
In the event there are further questions about this report, please contact: Name: <u>Brother Damien</u> Telephone Number: <u>(815) 694-2306</u>			

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Arthur Merkle Clara Knipprath Nursing Home# 0021832 Report Period Beginning: 1/1/03 Ending: 12/31/03

III. STATISTICAL DATA

A. Licensure/certification level(s) of care; enter number of beds/bed days,
(must agree with license). Date of change in licensed beds _____

	1	2	3	4	
	Beds at Beginning of Report Period	Licensure Level of Care	Beds at End of Report Period	Licensed Bed Days During Report Period	
1	<u>99</u>	Skilled (SNF)	<u>99</u>	<u>36,135</u>	1
2		Skilled Pediatric (SNF/PED)			2
3		Intermediate (ICF)			3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	<u>99</u>	TOTALS	<u>99</u>	<u>36,135</u>	7

B. Census-For the entire report period.

	1	2	3	4	5	
	Level of Care	Patient Days by Level of Care and Primary Source of Payment				
		Public Aid Recipient	Private Pay	Other	Total	
8	SNF	<u>10</u>	<u>1,198</u>		<u>1,208</u>	8
9	SNF/PED					9
10	ICF	<u>8,798</u>	<u>12,456</u>		<u>21,254</u>	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	<u>8,808</u>	<u>13,654</u>		<u>22,462</u>	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed
bed days on line 7, column 4.) 62.16%

D. How many bed-hold days during this year were paid by Public Aid?

0 (Do not include bed-hold days in Section B.)E. List all services provided by your facility for non-patients.
(E.g., day care, "meals on wheels", outpatient therapy)Meals on Wheels

F. Does the facility maintain a daily midnight census?

YesG. Do pages 3 & 4 include expenses for services or
investments not directly related to patient care?YES ☒ NO ☐

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?

YES ☒ NO ☐

I. On what date did you start providing long term care at this location?

Date started 10/6/75

J. Was the facility purchased or leased after January 1, 1978?

YES ☐ Date _____ NO ☒

K. Was the facility certified for Medicare during the reporting year?

YES ☐ NO ☒ If YES, enter number
of beds certified _____ and days of care provided _____

Medicare Intermediary _____

IV. ACCOUNTING BASIS

ACCRUAL ☒ MODIFIED CASH* ☐ CASH* ☐Is your fiscal year identical to your tax year? YES ☒ NO ☐Tax Year: 12/31/03 Fiscal Year: 12/31/03

* All facilities other than governmental must report on the accrual basis.

SEE ACCOUNTANTS' COMPILATION REPORT

STATE OF ILLINOIS

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Facility Name & ID Number Arthur Merkle Clara Knipprath Nursing Home # 0021832 Report Period Beginning: 1/1/03 Ending: 12/31/03

V. COST CENTER EXPENSES (throughout the report, please round to the nearest dollar)

	Operating Expenses	Costs Per General Ledger				Reclass-ification 5	Reclassified Total 6	Adjust-ments 7	Adjusted Total 8	FOR OHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10	
	A. General Services											
1	Dietary	250,322	18,319	13,383	282,024		282,024		282,024			1
2	Food Purchase		136,236		136,236	(18,900)	117,336	(9,718)	107,618			2
3	Housekeeping	72,161	339	9,727	82,227		82,227	(11,578)	70,649			3
4	Laundry	27,016	3,898	5,937	36,851		36,851		36,851			4
5	Heat and Other Utilities			124,752	124,752	(2,565)	122,187	(28,344)	93,843			5
6	Maintenance	73,281	3,687	9,813	86,781	(137)	86,644	(12,905)	73,739			6
7	Other (specify):* ILU Exp			1,328	1,328		1,328		1,328			7
8	TOTAL General Services	422,780	162,479	164,940	750,199	(21,602)	728,597	(62,545)	666,052			8
	B. Health Care and Programs											
9	Medical Director			4,200	4,200		4,200		4,200			9
10	Nursing and Medical Records	835,043	62,226	2,557	899,826		899,826	(13,500)	886,326			10
10a	Therapy	15,177			15,177		15,177		15,177			10a
11	Activities	59,096	9,234	8,130	76,460		76,460	(3,715)	72,745			11
12	Social Services	19,124			19,124		19,124		19,124			12
13	Nurse Aide Training											13
14	Program Transportation			1,094	1,094		1,094		1,094			14
15	Other (specify):* Cost of Sundries			803	803		803	(803)				15
16	TOTAL Health Care and Programs	928,440	71,460	16,784	1,016,684		1,016,684	(18,018)	998,666			16
	C. General Administration											
17	Administrative	75,000			75,000	6,192	81,192	(21,192)	60,000			17
18	Directors Fees											18
19	Professional Services			19,166	19,166		19,166		19,166			19
20	Dues, Fees, Subscriptions & Promotions			4,543	4,543		4,543		4,543			20
21	Clerical & General Office Expenses	82,364	3,228	7,413	93,005		93,005	(101)	92,904			21
22	Employee Benefits & Payroll Taxes			348,341	348,341	18,900	367,241	(5,125)	362,116			22
23	Inservice Training & Education			874	874		874		874			23
24	Travel and Seminar			60	60		60		60			24
25	Other Admin. Staff Transportation			851	851		851		851			25
26	Insurance-Prop.Liab.Malpractice			24,910	24,910	(207)	24,703	(2,318)	22,385			26
27	Other (specify):*											27
28	TOTAL General Administration	157,364	3,228	406,158	566,750	24,885	591,635	(28,736)	562,899			28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	1,508,584	237,167	587,882	2,333,633	3,283	2,336,916	(109,299)	2,227,617			29

* Attach a schedule if more than one type of cost is included on this line, or if the total exceeds \$1000.

SEE ACCOUNTANTS' COMPILATION REPORT

NOTE: Include a separate schedule detailing the reclassifications made in column 5. Be sure to include a detailed explanation of each reclassification.

STATE OF ILLINOIS

Page 4

Facility Name & ID Number Arthur Merkle Clara Knipprath Nursing Home #0021832 Report Period Beginning: 1/1/03 Ending: 12/31/03

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass- ification 5	Reclassified Total 6	Adjust- ments 7	Adjusted Total 8	FOR OHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10	
	D. Ownership											
30	Depreciation			214,780	214,780	(3,283)	211,497	(80,139)	131,358			30
31	Amortization of Pre-Op. & Org.											31
32	Interest											32
33	Real Estate Taxes											33
34	Rent-Facility & Grounds											34
35	Rent-Equipment & Vehicles											35
36	Other (specify):*											36
37	TOTAL Ownership			214,780	214,780	(3,283)	211,497	(80,139)	131,358			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers											39
40	Barber and Beauty Shops		10	16,764	16,774		16,774	(16,774)				40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			54,203	54,203		54,203		54,203			42
43	Other (specify):*											43
44	TOTAL Special Cost Centers		10	70,967	70,977		70,977	(16,774)	54,203			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	1,508,584	237,177	873,629	2,619,390		2,619,390	(206,212)	2,413,178			45

*Attach a schedule if more than one type of cost is included on this line, or if the total exceeds \$1000.

SEE ACCOUNTANTS' COMPILATION REPORT

Arthur Merkle Clara Knipprath Nursing Home
ID# #0021832
Report Period 1/1/03 to 12/31/03
Schedule V Attachment - Reclassification

Food Purchase	Line 2, Col 5	(\$18,900)
Employee Benefits and Payroll Taxes (To reclassify employee meals)	Line 22, Col 5	18,900
Heat & Other Utilities	Line 5, Col 5	(2,565)
Maintenance	Line 6, Col 5	(137)
Insurance, Property and Liability	Line 26, Col 5	(207)
Depreciation	Line 30, Col 5	(3,283)
Administrative (To reclassify administrative costs for Brothers' residence)	Line 17, Col 5	<u>6,192</u>
Total Reclassification	Line 45, Col 5	<u><u>\$0</u></u>

Facility Name & ID Number **Arthur Merkle Clara Knipprath Nursing Home**# **0021832**Report Period Beginning: **1/1/03**Ending: **12/31/03****VI. ADJUSTMENT DETAIL****A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7.****In column 2 below, reference the line on which the particular cost was included. (See instructions.)**

	NON-ALLOWABLE EXPENSES	1 Amount	2 Refer- ence	3 OHF USE ONLY	
1	Day Care	\$		\$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals	(4,505)	2		4
5	Telephone, TV & Radio in Resident Rooms	(3,715)	11		5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation	6,481	30		9
10	Interest and Other Investment Income				10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax				13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees				17
18	Fines and Penalties				18
19	Entertainment				19
20	Contributions				20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt				24
25	Fund Raising, Advertising and Promotional				25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	Nurse Aide Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule	(204,473)			29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (206,212)		\$	30

OHF USE ONLY						
48		49	50	51	52	

B. If there are expenses experienced by the facility which do not appear in the general ledger, they should be entered below.(See instructions.)

		1 Amount	2 Reference	
31	Non-Paid Workers-Attach Schedule*	\$		31
32	Donated Goods-Attach Schedule*			32
	Amortization of Organization &			
33	Pre-Operating Expense			33
	Adjustments for Related Organization			
34	Costs (Schedule VII)			34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$		36
	(sum of SUBTOTALS			
37	TOTAL ADJUSTMENTS (A) and (B))	\$ (206,212)		37

*These costs are only allowable if they are necessary to meet minimum licensing standards. Attach a schedule detailing the items included on these lines.

C. Are the following expenses included in Sections A to D of pages 3 and 4? If so, they should be reclassified into Section E. Please reference the line on which they appear before reclassification. (See instructions.)

		1 Yes	2 No	3 Amount	4 Reference	
38	Medically Necessary Transport.		x	\$		38
39			x			39
40	Gift and Coffee Shops		x			40
41	Barber and Beauty Shops		x			41
42	Laboratory and Radiology		x			42
43	Prescription Drugs		x			43
44	Exceptional Care Program		x			44
45	Other-Attach Schedule		x			45
46	Other-Attach Schedule		x			46
47	TOTAL (C): (sum of lines 38-46)			\$		47

SEE ACCOUNTANTS' COMPILATION REPORT

Arthur Merkle Clara Knipprath Nursing Home

ID# 0021832

Report Period Beginning: 1/1/03

Ending: 12/31/03

Sch. V Line

NON-ALLOWABLE EXPENSES		Amount	Reference	
1	Independent Living Unit -Maintenance Wages	\$ (10,000)	6	1
2	Independent Living Unit Wages	(13,500)	10	2
3	Independent Living Unit Wages - Administration	(15,000)	17	3
4	Independent Living Unit Employee Benefits	(5,125)	22	4
5	Independent Living Unit Wages	(11,578)	3	5
6	Independent Living Unit Insurance	(2,318)	26	6
7	Independent Living Unit Depreciation	(86,620)	30	7
8	Independent Living Unit Utilities	(28,344)	5	8
9	Independent Living Unit-Supplies	(101)	21	9
10	Independent Living Unit Maintenance & Other	(2,905)	6	10
11	Independent Living Unit Food Cost	(5,213)	2	11
12	Administration Cost for Brothers' Residence	(6,192)	17	12
13	Adjust Barber & Beauty due to income received	(16,774)	40	13
14	Adj Sundried due to income received	(803)	15	14
15				15
16				16
17				17
18				18
19				19
20				20
21				21
22				22
23				23
24				24
25				25
26				26
27				27
28				28
29				29
30				30
31				31
32				32
33				33
34				34
35				35
36				36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	Total	(204,473)		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Arthur Merkle Clara Knipprath Nursing Home

0021832

Report Period Beginning:

1/1/03

Ending:

12/31/03

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Operating Expenses	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
	A. General Services													
1	Dietary	0	0	0	0	0	0	0	0	0	0	0	0	1
2	Food Purchase	(9,718)	0	0	0	0	0	0	0	0	0	0	(9,718)	2
3	Housekeeping	(11,578)	0	0	0	0	0	0	0	0	0	0	(11,578)	3
4	Laundry	0	0	0	0	0	0	0	0	0	0	0	0	4
5	Heat and Other Utilities	(28,344)	0	0	0	0	0	0	0	0	0	0	(28,344)	5
6	Maintenance	(12,905)	0	0	0	0	0	0	0	0	0	0	(12,905)	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	TOTAL General Services	(62,545)	0	0	0	0	0	0	0	0	0	0	(62,545)	8
	B. Health Care and Programs													
9	Medical Director	0	0	0	0	0	0	0	0	0	0	0	0	9
10	Nursing and Medical Records	(13,500)	0	0	0	0	0	0	0	0	0	0	(13,500)	10
10a	Therapy	0	0	0	0	0	0	0	0	0	0	0	0	10a
11	Activities	(3,715)	0	0	0	0	0	0	0	0	0	0	(3,715)	11
12	Social Services	0	0	0	0	0	0	0	0	0	0	0	0	12
13	Nurse Aide Training	0	0	0	0	0	0	0	0	0	0	0	0	13
14	Program Transportation	0	0	0	0	0	0	0	0	0	0	0	0	14
15	Other (specify):*	(803)	0	0	0	0	0	0	0	0	0	0	(803)	15
16	TOTAL Health Care and Programs	(18,018)	0	0	0	0	0	0	0	0	0	0	(18,018)	16
	C. General Administration													
17	Administrative	(21,192)	0	0	0	0	0	0	0	0	0	0	(21,192)	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	0	0	0	0	0	0	0	0	0	0	0	0	19
20	Fees, Subscriptions & Promotions	0	0	0	0	0	0	0	0	0	0	0	0	20
21	Clerical & General Office Expenses	(101)	0	0	0	0	0	0	0	0	0	0	(101)	21
22	Employee Benefits & Payroll Taxes	(5,125)	0	0	0	0	0	0	0	0	0	0	(5,125)	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	0	0	0	0	0	0	0	0	0	0	0	0	24
25	Other Admin. Staff Transportation	0	0	0	0	0	0	0	0	0	0	0	0	25
26	Insurance-Prop.Liab.Malpractice	(2,318)	0	0	0	0	0	0	0	0	0	0	(2,318)	26
27	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	27
28	TOTAL General Administration	(28,736)	0	0	0	0	0	0	0	0	0	0	(28,736)	28
29	TOTAL Operating Expense (sum of lines 8,16 & 28)	(109,299)	0	0	0	0	0	0	0	0	0	0	(109,299)	29

Summary B

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

[illegible]

VII. RELATED PARTIES

A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Attach an additional schedule if necessary.

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
Fransiscan Missionary Brothers of the Sacred Heart of Jesus	100%	N/A				

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☐ YES ☒ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
1	V			\$			\$	\$	1
2	V								2
3	V								3
4	V								4
5	V								5
6	V								6
7	V								7
8	V								8
9	V								9
10	V								10
11	V								11
12	V								12
13	V								13
14	Total			\$			\$	\$ *	14

* Total must agree with the amount recorded on line 34 of Schedule VI.

SEE ACCOUNTANTS' COMPILATION REPORT

STATE OF ILLINOIS

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Facility Name & ID Number Arthur Merkle Clara Knipprath Nursing Ho # 0021832 Report Period Beginning: 1/1/03 Ending: 12/31/03

VII. RELATED PARTIES (continued)

C. Statement of Compensation and Other Payments to Owners, Relatives and Members of Board of Directors.

NOTE: ALL owners (even those with less than 5% ownership) and their relatives who receive any type of compensation from this home must be listed on this schedule.

	1 Name	2 Title	3 Function	4 Ownership Interest	5 Compensation Received From Other Nursing Homes*	6 Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		7 Compensation Included in Costs for this Reporting Period**		8 Schedule V. Line & Column Reference
						Hours	Percent	Description	Amount	
1	Bro Damien Dabraekeleer	Executive Director	Administrator	0.00	0	46	100.00	Stipend to	\$ 75,000	1
2	Bro William Farrelly	Director	Nursing	0.00	0	44	100.00	Religious	67,500	2
3	Bro Joseph Ruscha	Director	Maintenance	0.00	0	44	100.00	Order	49,996	3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13								TOTAL	\$ 192,496	13

* If the owner(s) of this facility or any other related parties listed above have received compensation from other nursing homes, attach a schedule detailing the name(s) of the home(s) as well as the amount paid. THIS AMOUNT MUST AGREE TO THE AMOUNTS CLAIMED ON THE THE OTHER NURSING HOMES' COST REPORTS.

** This must include all forms of compensation paid by related entities and allocated to Schedule V of this report (i.e., management fees).
FAILURE TO PROPERLY COMPLETE THIS SCHEDULE INDICATING ALL FORMS OF COMPENSATION RECEIVED FROM THIS HOME.
ALL OTHER NURSING HOMES AND MANAGEMENT COMPANIES MAY RESULT IN THE DISALLOWANCE OF SUCH COMPENSATION

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Arthur Merkle Clara Knipprath Nursing Home # 0021832 Report Period Beginning: 1/1/03 Ending: 12/31/03

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☐ NO ☒

Name of Related Organization _____
 Street Address _____
 City / State / Zip Code _____
 Phone Number () _____
 Fax Number () _____

B. Show the allocation of costs below. If necessary, please attach worksheets.

1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e., Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1					\$	\$		\$	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25	TOTALS				\$	\$		\$	25

SEE ACCOUNTANTS' COMPILATION REPORT

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)

1		2		3	4	5	6		7	8	9	10	
	Name of Lender	Related**		Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense		
		YES	NO				Original	Balance					
	A. Directly Facility Related												
	Long-Term												
1	None						\$	\$			\$	1	
2												2	
3												3	
4												4	
5												5	
	Working Capital												
6	None											6	
7												7	
8												8	
9	TOTAL Facility Related						\$	\$			\$	9	
	B. Non-Facility Related*												
10	None											10	
11												11	
12												12	
13												13	
14	TOTAL Non-Facility Related						\$	\$			\$	14	
15	TOTALS (line 9+line14)						\$	\$			\$	15	

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. \$ _____ Line # _____

* Any interest expense reported in this section should be adjusted out on page 5, line 14 and, consequently, page 4, col. 7.
(See instructions.) SEE ACCOUNTANTS' COMPILATION REPORT

** If there is ANY overlap in ownership between the facility and the lender, this must be indicated in column 2.
(See instructions.)

Facility Name & ID Number Arthur Merkle Clara Knipprath Nursing Home

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE (continued)

B. Real Estate Taxes

	Important , please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.	\$	Tax Exempt	1
1. Real Estate Tax accrual used on 2002 report.		\$		1
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)		\$		2
3. Under or (over) accrual (line 2 minus line 1).		\$		3
4. Real Estate Tax accrual used for 2003 report. (Detail and explain your calculation of this accrual on the lines below.)		\$		4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. (Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)		\$		5
6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. TOTAL REFUND \$ _____ For _____ Tax Year. (Attach a copy of the real estate tax appeal board's decision.)		\$		6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.		\$		7
Real Estate Tax History:				
Real Estate Tax Bill for Calendar Year:	1998 1999 2000 2001 2002	<div></div> <div></div> <div></div> <div></div> <div></div>	FOR OHF USE ONLY	8 9 10 11 12
			13 FROM R. E. TAX STATEMENT FOR 2002 \$	13
			14 PLUS APPEAL COST FROM LINE 5 \$	14
			15 LESS REFUND FROM LINE 6 \$	15
			16 AMOUNT TO USE FOR RATE CALCULATION \$	16

NOTES:

1. Please indicate a negative number by use of brackets (). Deduct any overaccrual of taxes from prior year.
2. If facility is a non-profit which pays real estate taxes, you must attach a denial of an application for real estate tax exemption unless the building is rented from a for-profit entity.
This denial must be no more than four years old at the time the cost report is filed.

SEE ACCOUNTANTS' COMPILATION REPORT

IMPORTANT NOTICE

TO: Long Term Care Facilities with Real Estate Tax Rates **RE:** 2002 REAL ESTATE TAX COST DOCUMENTATION

In order to set the real estate tax portion of the capital rate, it is necessary that we obtain additional information regarding your calendar 2002 real estate tax costs, as well as copies of your real estate tax bills for calendar 2002.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2002 real estate tax bill to the Department of Public Aid, Office of Health Finance, 201 South Grand Avenue East, Springfield, Illinois 62763.

Please send these items in with your completed 2003 cost report. The cost report will not be considered complete and timely filed until this statement and the corresponding real estate tax bills are filed. If you have any questions, please call the Office of Health Finance at (217) 782-1630.

2002 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Arthur Merkle Clara Knipprath Nursing Home COUNTY Iroquois

FACILITY IDPH LICENSE NUMBER 0021832

CONTACT PERSON REGARDING THIS REPORT _____

TELEPHONE () FAX #: ()

A. Summary of Real Estate Tax Cost

Enter the tax index number and real estate tax assessed for 2002 on the lines provided below. Enter only the portion of the cost that applies to the operation of the nursing home in Column D. Real estate tax applicable to any portion of the nursing home property which is vacant, rented to other organizations, or used for purposes other than long term care must not be entered in Column D. Do not include cost for any period other than calendar year 2002.

	(A)	(B)	(C)	(D) <u>Tax</u>
	<u>Tax Index Number</u>	<u>Property Description</u>	<u>Total Tax</u>	<u>Applicable to</u> <u>Nursing Home</u>
1.	_____	_____	\$ _____	\$ _____
2.	_____	_____	\$ _____	\$ _____
3.	_____	_____	\$ _____	\$ _____
4.	_____	_____	\$ _____	\$ _____
5.	_____	_____	\$ _____	\$ _____
6.	_____	_____	\$ _____	\$ _____
7.	_____	_____	\$ _____	\$ _____
8.	_____	_____	\$ _____	\$ _____
9.	_____	_____	\$ _____	\$ _____
10.	_____	_____	\$ _____	\$ _____
		TOTALS	\$ <u> </u>	\$ <u> </u>

B. Real Estate Tax Cost Allocations

Does any portion of the tax bill apply to more than one nursing home, vacant property, or property which is not directly used for nursing home services? _____ YES _____ NO

If YES, attach an explanation & a schedule which shows the calculation of the cost allocated to the nursing home.
(Generally the real estate tax cost must be allocated to the nursing home based upon sq. ft. of space used.)

C. Tax Bills

Attach a copy of the 2002 tax bills which were listed in Section A to this statement. Be sure to use the 2002 tax bill which is normally paid during 2003.

A. Square Feet:
 53,919

B. General Construction Type:
 Exterior
 Brick
 Frame
 Masonry
 Number of Stories
 1

C. Does the Operating Entity?
 ☒ (a) Own the Facility
 ☐ (b) Rent from a Related Organization.
 ☐ (c) Rent from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI. Those checking (c) may complete Schedule XI or Schedule XII-A. See instructions.)

D. Does the Operating Entity?
 ☒ (a) Own the Equipment
 ☐ (b) Rent equipment from a Related Organization.
 ☐ (c) Rent equipment from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions.)

E. List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's grounds (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, nurse aide training facilities, etc.) List entity name, type of business, square footage, and number of beds/units available (where applicable).

Countryside Villas, 15 Unit Independent Living Units - 17005 square feet

F. Does this cost report reflect any organization or pre-operating costs which are being amortized?
 ☐ YES
 ☒ NO

If so, please complete the following:

1. Total Amount Incurred:
 2. Number of Years Over Which it is Being Amortized:

3. Current Period Amortization:
 4. Dates Incurred:

Nature of Costs:
 (Attach a complete schedule detailing the total amount of organization and pre-operating costs.)

XI. OWNERSHIP COSTS:

A. Land.

	1	2	3	4	
	Use	Square Feet	Year Acquired	Cost	
1	SNF	1,730,560	1975	\$ 24,225	1
2	Farm/ILU	995,072	1975	32,775	2
3	TOTALS	2,725,632		\$ 57,000	3

SEE ACCOUNTANTS' COMPILATION REPORT

STATE OF ILLINOIS

Page 12

Facility Name & ID Number Arthur Merkle Clara Knipprath Nursing Home

0021832

Report Period Beginning:

1/1/03

Ending:

12/31/03

XI. OWNERSHIP COSTS (continued)**B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.**

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4	99		1975	1975	\$ 773,471	\$ 16,432	33	\$ 16,432		\$ 608,262	4
5			1975	1975	432,948	8,539	25	8,539		392,116	5
6											6
7											7
8											8
9	Improvement Type**										
10	Fixed Equipment			1981	924		5			924	9
11				1982	656		15			656	10
12				1983	5,462	138	17	138		5,254	11
13				1984	16,618	588	15	588		16,325	12
14				1985	6,098	190	15	190		4,761	13
15				1986	2,400		10			2,400	14
16				1987	6,773		25			6,773	15
17				1988	650	22	10	22		650	16
18				1979	2,032		5			2,032	17
19				1980	14,012		15			14,012	18
20				1989	9,327	388	20	388		6,384	19
21				1990	1,276		10			1,276	20
22				1991	25,219	1,231	20	1,231		15,986	21
23				1992	6,594	440	15	440		5,056	22
24				1993	2,825	141	10	141		2,825	23
25				1995	97,366	4,109	25	4,109		34,926	24
26	Fire Supression-Kitchen			1996	2,115	106	20	106		793	25
27	Nurses Station Impr			1996	5,395	360	15	360		2,698	26
28	Verticla Blinds-Arthur			1996	350	35	10	35		262	27
29	Heat pump compressor			1996	1,890	189	10	189		1,418	28
30	Therapy Room Cubicle			1996	321	32	10	32		241	29
31	Kitchen Heat Pump			1996	1,679	168	10	168		1,259	30
32	2 Water Heaters			1996	4,158	277	15	277		2,079	31
33	Call Light System			1996	1,348	90	15	90		674	32
34	Room Heaters			1996	3,603	360	10	360		2,702	33
35	Pump/Generator Impr			1997	2,540		5			2,540	34
36	Fire Alarm Impr			1997	1,105		5			1,105	35
37	Fire Safety Code Impr			1997	5,844	390	15	390		2,533	36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

See Page 12A, Line 70 for total

SEE ACCOUNTANTS' COMPILATION REPORT

STATE OF ILLINOIS

Page 12A

Facility Name & ID Number Arthur Merkle Clara Knipprath Nursing Home

0021832

Report Period Beginning:

1/1/03

Ending:

12/31/03

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1	2	3	4	5	6	7	8	9	
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation		
37	Procure Nurse Call System	1997	\$ 36,033	\$ 2,402	15	\$ 2,402	\$	\$ 15,614		37
38	Garbage Disposal	1998	1,142	76	15	76		419		38
39	Heat Pump	1998	2,853	285	10	285		1,569		39
40	Fire Door	1998	200	10	20	10		55		40
41										41
42	Room Heat/Cool Unit	1998	3,632	363	10	363		1,997		42
43	Generator	1998	141,059	7,053	20	7,053		38,791		43
44	Cubicle Curtains	1998	5,250	525	10	525		2,888		44
45	Register Covers	1999	1,056	105	10	105		475		45
46	Walk-in Freezer/Cooler	1999	20,126	805	25	805		3,623		46
47	Water Heater Booster	1999	1,131	113	10	113		509		47
48	Above Ground Tank	1999	1,495	150	10	150		673		48
49										49
50	Air/Heat Unit	1999	1,057	212	5	212		952		50
51	Air Return Extension	2000	1,532	102	15	102		357		51
52	SS Garbage Disposal	2000	527	26	20	26		92		52
53	(2) Air /Heat Units	2000	1,950	390	5	390		1,365		53
54	Resident Security System	2001	4,830	483	10	483		1,208		54
55	Sewage Component Impr	2001	4,549	303	15	303		758		55
56	Disposal	2001	549	55	10	55		137		56
57	Dehumidifier	2001	1,050	105	10	105		263		57
58	Chapel Heating/Cooling	2001	19,000	1,901	10	1,901		4,750		58
59	Natural Gas Hot Water Conversion	2002	29,705	1,980	15	1,980		2,970		59
60	Resident Hall Water Coolers	2002	1,657	166	10	166		249		60
61	Sewer Lagoon Impr	2002	6,824	683	10	683		1,024		61
62	Time Clock	2002	395	39	10	39		59		62
63	Resident Room Heat/Cool Unit	2003	3,470	116	15	116		116		63
64	Satellite	2003	782	78	5	78		78		64
65	Front Entrance Door	2003	3,612	181	10	181		181		65
66	Exterior Security Locks	2003	612	31	10	31		31		66
67	Closet Doors	2003	2,845	95	15	95		95		67
68	DR Rooftop Heating Unit	2003	6,325	211	15	211		211		68
69	Staff DR Cooling Unit	2003	2,600	87	15	87		87		69
70	TOTAL (lines 4 thru 69)		\$ 1,742,847	\$ 53,356		\$ 53,356	\$	\$ 1,220,518		70

SEE ACCOUNTANTS' COMPILATION REPORT

**Improvement type must be detailed in order for the cost report to be considered complete.

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

1	2	3	4	5	6	7	8	9	10
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1	Totals from Page 12A, Carried Forward		\$ 1,742,847	\$ 53,356		\$ 53,356		\$ 1,220,518	1
2	Land Improvements	1975	194,467	2,900	25	2,900		161,123	2
3		1979	8,614		20			8,614	3
4		1982	42,700		11			42,700	4
5		1983	1,999	50	20	50		1,999	5
6		1984	3,405	171	20	171		3,319	6
7		1985	860		12			860	7
8		1986	6,156		15			6,156	8
9		1980	762		20			762	9
10		1992	6,346	317	20	317		3,649	10
11		1993	3,640		5			3,640	11
12		1995	6,753	412	15	412		3,508	12
13	Drive Pavement	1997	8,900	594	15	594		3,857	13
14	Well	1998	7,339	367	20	367		2,018	14
15	Sewer Improvement	1999	13,399	1,340	10	1,340		6,030	15
16	Drive Sealing	2000	8,945	1,789	5	1,789		6,262	16
17	Landscaping	2002	4,211	281	15	281		421	17
18	Drive Widening	2002	32,150	3,215	10	3,215		4,823	18
19	Sewage System Control Panel	2003	2,635	132	10	132		132	19
20	Water Well Improvement	2003	7,449	372	10	372		372	20
21									21
22	Buildings	1980	4,422		20			4,422	22
23		1981	1,738		10			1,738	23
24		1982	1,106	45	25	45		952	24
25		1984	130,023	19	20	6,500	6,481	123,526	25
26		1985	598		15			598	26
27		1986	640,838	20,157	33	20,157		367,287	27
28		1987	37,528	44	15	44		37,528	28
29		1988	13,228	441	15	441		13,228	29
30		1989	10,488	99	15	99		10,438	30
31		1990	2,096		10			2,096	31
32		1991	35,542	1,815	20	1,815		22,687	32
33		1992	(34,187)	(810)	40	(810)		(9,315)	33
34	TOTAL (lines 1 thru 33)		\$ 2,946,997	\$ 87,106		\$ 93,587	\$ 6,481	\$ 2,055,948	34

SEE ACCOUNTANTS' COMPILATION REPORT

**Improvement type must be detailed in order for the cost report to be considered complete.

XI. OWNERSHIP COSTS (continued)									
B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.									
1	2	3	4	5	6	7	8	9	
Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation		
1	Totals from Page 12B, Carried Forward	\$ 2,946,997	\$ 87,106		\$ 93,587	\$ 6,481	\$ 2,055,948		1
2	1993	475	24	10	24		475		2
3	Floor Tile Nurse Station	2,050	137	15	137		1,025		3
4	Floor Tile Clara Wing	778	52	15	52		389		4
5	Floor Tile, Main, Kitchen	14,739	2,105	7	2,105		13,686		5
6	Hallway Impr	3,870		5			3,870		6
7	Roof Improvements	13,828	921	15	921		5,992		7
8	Floor Tile Arthur Wing	6,475	647	10	647		3,561		8
9	DR Vinyl Floor	4,420	884	5	884		3,978		9
10	Interior Coridor Doors	2,415	161	10	161		564		10
11	Chapel Roof (Partial)	3,099	207	15	207		517		11
12	Kitchen Doors	1,031	103	10	103		258		12
13	New Roof	32,319	1,616	20	1,616		2,424		13
14	Floor Tile	2,919	195	15	195		292		14
15	Maintenance Shed	7,010	281	25	281		421		15
16	North Wing Roof	34,539	863	20	863		863		16
17	Chapel Windows	18,234	456	20	456		456		17
18	Resident Room Tiling	1,521	76	10	76		76		18
19	Chapel Entry Flooring	2,924	146	10	146		146		19
20									20
21									21
22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)	\$ 3,099,643	\$ 95,980		\$ 102,461	\$ 6,481	\$ 2,094,941		34

SEE ACCOUNTANTS' COMPILATION REPORT

**Improvement type must be detailed in order for the cost report to be considered complete.

Arthur Merkle Clara Knipprath Nursing Home
ID# 0021832
Report Period Beginning 1/1/03 to 12/31/03
Attachment to Schedule XI, Page 12B, Line 25

The Nursing Home received an adjustment on building improvements constructed in 1982 due to construction problems relating to leakage in the chapel roof. This amount is reflected as a 1992 line item and adjusted prospectively.

C. Equipment Depreciation-Excluding Transportation. (See instructions.)

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	\$ 277,363	\$ 22,690	\$ 22,690	\$	Various	\$ 128,411	71
72	Current Year Purchases	6,275	314	314		Various	314	72
73	Fully Depreciated Assets	164,823				Various	164,823	73
74								74
75	TOTALS	\$ 448,461	\$ 23,004	\$ 23,004	\$		\$ 293,548	75

D. Vehicle Depreciation (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76	Patient Transport	1996 Ford Eldorado Transit	1996	\$ 38,099	\$ 3,810	\$ 3,810	\$	10	\$ 28,574	76
77	Facility Business	1996 Mercury Sable	1996	15,878				4	15,878	77
78	Patient Transport	1993 Mercury Villager	1992	18,387				5	18,387	78
79	Maintenance Truck	1997 GMC Truck	2002	14,580	2,083	2,083		7	3,124	79
80	TOTALS			\$ 86,944	\$ 5,893	\$ 5,893	\$		\$ 65,963	80

E. Summary of Care-Related Assets

	1 Reference	2 Amount	
81	Total Historical Cost (line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	\$ 3,692,048	81
82	Current Book Depreciation (line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 124,877	82
83	Straight Line Depreciation (line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 131,358	83 **
84	Adjustments (line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ 6,481	84
85	Accumulated Depreciation (line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 2,454,452	85

F. Depreciable Non-Care Assets Included in General Ledger. (See instructions.)

	1 Description & Year Acquired	2 Cost	Current Book Depreciation 3	Accumulated Depreciation 4	
86	Brother Residence	\$ 94,816	\$ 2,370	\$ 67,554	86
87	Brother Residence Equipment	20,342	913	13,192	87
88	Apartment Complex Bldg	1,786,199	52,568	611,386	88
89	Apartment Complex Equipment	727,451	32,986	398,331	89
90	Apartment Complex Land Impr	21,325	1,066	12,795	90
91	TOTALS	\$ 2,650,133	\$ 89,903	\$ 1,103,258	91

G. Construction-in-Progress

	Description	Cost	
92		\$	92
93			93
94			94
95		\$	95

* Vehicles used to transport residents to & from day training must be recorded in XI-F, not XI-D.

** This must agree with Schedule V line 30, column 8.

SEE ACCOUNTANTS' COMPILATION REPORT

1. Name of Party Holding Lease: N/A

If NO, see instructions.

SEE ACCOUNTANTS' COMPILATION REPORT

A. TYPE OF TRAINING PROGRAM (If aides are trained in another facility program, attach a schedule listing the facility name, address and cost per aide trained in that facility.)

1. HAVE YOU TRAINED AIDES DURING THIS REPORT PERIOD? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.	2. CLASSROOM PORTION: IN-HOUSE PROGRAM <input type="checkbox"/> IN OTHER FACILITY <input type="checkbox"/> COMMUNITY COLLEGE <input type="checkbox"/> HOURS PER AIDE _____	3. CLINICAL PORTION: IN-HOUSE PROGRAM <input type="checkbox"/> IN OTHER FACILITY <input type="checkbox"/> HOURS PER AIDE _____
---	---	--

All new nurses aids are required to have completed the proper training prior to being hired.

B. EXPENSES

ALLOCATION OF COSTS (d)

		1		2		3	4
		Facility					
		Drop-outs	Completed	Contract	Total		
1	Community College Tuition	\$	\$	\$	\$		
2	Books and Supplies						
3	Classroom Wages (a)						
4	Clinical Wages (b)						
5	In-House Trainer Wages (c)						
6	Transportation						
7	Contractual Payments						
8	Nurse Aide Competency Tests						
9	TOTALS	\$	\$	\$	\$		
10	SUM OF line 9, col. 1 and 2 (e)	\$					

- (a) Include wages paid during the classroom portion of training. Do not include fringe benefits.
 (b) Include wages paid during the clinical portion of training. Do not include fringe benefits.
 (c) For in-house training programs only. Do not include fringe benefits.
 (d) Allocate based on if the aide is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own aides.

C. CONTRACTUAL INCOME

In the box below record the amount of income your facility received training aides from other facilities.

\$

D. NUMBER OF AIDES TRAINED

COMPLETED	
1. From this facility	
2. From other facilities (f)	
DROP-OUTS	
1. From this facility	
2. From other facilities (f)	
TOTAL TRAINED	

- (e) The total amount of Drop-out and Completed Costs for your own aides must agree with Sch. V, line 13, col. 8.
 (f) Attach a schedule of the facility names and addresses of those facilities for which you trained aides.
 SEE ACCOUNTANTS' COMPILATION REPORT

XIV. SPECIAL SERVICES (Direct Cost) (See instructions.)

		1	2	3	4	5	6	7	8		
	Service	Schedule V Line & Column Reference	Staff		Outside Practitioner (other than consultant)		Supplies (Actual or Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)		
			Units of Service	Cost	Units	Cost					
					1	Licensed Occupational Therapist		hrs	\$		\$
	Licensed Speech and Language Development Therapist		hrs								2
2	Licensed Recreational Therapist		hrs								3
4	Licensed Physical Therapist		hrs								4
5	Physician Care		visits								5
6	Dental Care		visits								6
7	Work Related Program		hrs								7
8	Habilitation		hrs								8
9	Pharmacy		# of prescrpts								9
	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs								10
10	Academic Education		hrs								11
12	Exceptional Care Program										12
13	Other (specify):										13
14	TOTAL			\$		\$	\$		\$		14

NOTE: This schedule should include fees (other than consultant fees) paid to licensed practitioners. Consultant fees should be detailed on Schedule XVIII-B. Salaries of unlicensed practitioners, such as nurse aides, who help with the above activities should not be listed on this schedule.

SEE ACCOUNTANTS' COMPILATION REPORT

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	\$ 104,360	\$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance 16,000)	123,890		3
4	Supply Inventory (priced at)			4
5	Short-Term Investments	2,637,313		5
6	Prepaid Insurance	57,580		6
7	Other Prepaid Expenses			7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify): <u>Accrued Interest</u>	8,380		9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 2,931,523	\$	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments	475,459		12
13	Land	435,292		13
14	Buildings, at Historical Cost	3,650,553		14
15	Leasehold Improvements, at Historical Cost			15
16	Equipment, at Historical Cost	2,250,875		16
17	Accumulated Depreciation (book methods)	(3,557,800)		17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify):			23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 3,254,379	\$	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 6,185,902	\$	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 89,688	\$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	7,578		30
31	Accrued Taxes Payable (excluding real estate taxes)	2,739		31
32	Accrued Real Estate Taxes(Sch.IX-B)			32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	<u>Apartment Rental Deposits</u>	19,770		36
37				37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 119,775	\$	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable			40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43				43
44				44
45	TOTAL Long-Term Liabilities (sum of lines 39 thru 44)	\$	\$	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 119,775	\$	46
47	TOTAL EQUITY (page 18, line 24)	\$ 6,066,127	\$	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 6,185,902	\$	48

SEE ACCOUNTANTS' COMPILATION REPORT

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 6,138,667	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 6,138,667	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	(72,540)	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants		11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	()	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe)		15
16	Other (describe)		16
17	TOTAL Additions (deductions) (sum of lines 7-16)	\$ (72,540)	17
	B. Transfers (Itemize):		
18			18
19			19
20			20
21			21
22			22
23	TOTAL Transfers (sum of lines 18-22)	\$	23
24	BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)	\$ 6,066,127	24 *

* This must agree with page 17, line 47.

SEE ACCOUNTANTS' COMPILATION REPORT

STATE OF ILLINOIS

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Facility Name & ID Number Arthur Merkle Clara Knipprath Nursing Home # 0021832 Report Period Beginning: 1/1/03

Ending: 12/31/03

XVII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required classifications of revenue and expense must be provided on this form, even if financial statements are attached.

Note: This schedule should show gross revenue and expenses. Do not net revenue against expense.

		1	
Revenue		Amount	
A. Inpatient Care			
1	Gross Revenue -- All Levels of Care	\$ 2,920,707	1
2	Discounts and Allowances for all Levels	(751,796)	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 2,168,911	3
B. Ancillary Revenue			
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	7,337	6
7	Oxygen		7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 7,337	8
C. Other Operating Revenue			
9	Payments for Education		9
10	Other Government Grants		10
11	Nurses Aide Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care	23,727	13
14	Non-Patient Meals	16,773	14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs		17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray		20
21	Other Medical Services		21
22	Laundry		22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 40,500	23
D. Non-Operating Revenue			
24	Contributions	50,746	24
25	Interest and Other Investment Income***	75,776	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 126,522	26
E. Other Revenue (specify):****			
27	Settlement Income (Insurance, Legal, Etc.)		27
28	Rental & Farm	211,762	28
28a	Gain(Loss) on Disposal of Equipment	(8,182)	28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 203,580	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 2,546,850	30

		2	
Expenses		Amount	
A. Operating Expenses			
31	General Services	750,199	31
32	Health Care	1,016,684	32
33	General Administration	566,750	33
B. Capital Expense			
34	Ownership	214,780	34
C. Ancillary Expense			
35	Special Cost Centers	16,774	35
36	Provider Participation Fee	54,203	36
D. Other Expenses (specify):			
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 2,619,390	40
41	Income before Income Taxes (line 30 minus line 40)**	(72,540)	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ (72,540)	43

* This must agree with page 4, line 45, column 4.

** Does this agree with taxable income (loss) per Federal Income Tax Return? _____ If not, please attach a reconciliation.

*** See the instructions. If this total amount has not been offset against interest expense on Schedule V, line 32, please include a detailed explanation. SEE ACCOUNTANTS' COMPILATION REPORT

****Provide a detailed breakdown of "Other Revenue" on an attached sheet.

STATE OF ILLINOIS

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Facility Name & ID Number Arthur Merkle Clara Knipprath Nursing Home# 0021832Report Period Beginning: 1/1/03Ending: 12/31/03

XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)

(This schedule must cover the entire reporting period.)

		1	2**	3	4	
		# of Hrs. Actually Worked	# of Hrs. Paid and Accrued	Reporting Period Total Salaries, Wages	Average Hourly Wage	
1	Director of Nursing	2,050	2,234	\$ 55,846	\$ 25.00	1
2	Assistant Director of Nursing					2
3	Registered Nurses	7,533	8,325	167,236	20.09	3
4	Licensed Practical Nurses	13,052	14,316	216,694	15.14	4
5	Nurse Aides & Orderlies	40,817	44,226	395,728	8.95	5
6	Nurse Aide Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	1,664	1,792	17,290	9.65	8
9	Activity Director	1,746	1,953	21,909	11.22	9
10	Activity Assistants	3,750	4,199	38,659	9.21	10
11	Social Service Workers	1,660	1,804	17,645	9.78	11
12	Dietician					12
13	Food Service Supervisor	1,834	2,082	37,250	17.89	13
14	Head Cook	1,114	1,282	14,522	11.33	14
15	Cook Helpers/Assistants	21,117	23,053	206,632	8.96	15
16	Dishwashers					16
17	Maintenance Workers	4,232	4,457	63,608	14.27	17
18	Housekeepers	6,766	7,263	71,175	9.80	18
19	Laundry	3,430	3,659	32,590	8.91	19
20	Administrator	2,440	2,496	60,000	24.04	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	5,548	5,972	70,597	11.82	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records	2,288	2,568	21,203	8.26	31
32	Other Health Care(specify)					32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	121,041	131,681	\$ 1,508,584 *	\$ 11.46	34

* This total must agree with page 4, column 1, line 45.

** See instructions.

B. CONSULTANT SERVICES

		1	2	3	
		Number of Hrs. Paid & Accrued	Total Consultant Cost for Reporting Period	Schedule V Line & Column Reference	
35	Dietary Consultant	118	\$ 5,669	Ln 1, Col 3	35
36	Medical Director	36	4,200	Ln 9, Col 3	36
37	Medical Records Consultant				37
38	Nurse Consultant				38
39	Pharmacist Consultant	36	600	Ln 10, Col 3	39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant	185	1,138	Ln 11, Col 3	44
45	Social Service Consultant	195	1,083	Ln 11, Col 3	45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)	570	\$ 12,690		49

C. CONTRACT NURSES

		1	2	3	
		Number of Hrs. Paid & Accrued	Total Contract Wages	Schedule V Line & Column Reference	
50	Registered Nurses		\$		50
51	Licensed Practical Nurses				51
52	Nurse Aides				52
53	TOTAL (lines 50 - 52)		\$		53

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Arthur Merkle Clara Knipprath Nursing Home

0021832

Report Period Beginning: 1/1/03

Ending: 12/31/03

XIX. SUPPORT SCHEDULES

[illegible]

* Attach copy of IMRF notifications
SEE ACCOUNTANTS' COMPILATION REPORT

****See instructions.**

XIX-H. SUPPORT SCHEDULE - DEFERRED MAINTENANCE COSTS (which have been included in Sch. V, line 6, col. 3).
(See instructions.)

	1 Improvement Type	2 Month & Year Improvement Was Made	3 Total Cost	4 Useful Life	5 6 7 8 9 10 11 12 13 Amount of Expense Amortized Per Year								
					FY2000	FY2001	FY2002	FY2003	FY2004	FY2005	FY2006	FY2007	FY2008
1			\$		\$	\$	\$	\$	\$	\$	\$	\$	\$
2													
3													
4													
5													
6													
7													
8													
9													
10													
11													
12													
13													
14													
15													
16													
17													
18													
19													
20	TOTALS		\$		\$	\$	\$	\$	\$	\$	\$	\$	\$

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Arthur Merkle Clara Knipprath Nursing Home

STATE OF ILLINOIS

0021832

Report Period Beginning:

1/1/03

Ending:

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XX. GENERAL INFORMATION:

- (1) Are nursing employees (RN,LPN,NA) represented by a union? No
- (2) Are there any dues to nursing home associations included on the cost report? Yes
If YES, give association name and amount. \$3,920 Life Services Network
- (3) Did the nursing home make political contributions or payments to a political action organization? No If YES, have these costs been properly adjusted out of the cost report? _____
- (4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? No If YES, what is the capacity? _____
- (5) Have you properly capitalized all major repairs and equipment purchases? Yes
What was the average life used for new equipment added during this period? 12.33
- (6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. \$ 20,796 Line 10
- (7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? Yes If NO, attach a complete explanation.
- (8) Are you presently operating under a sale and leaseback arrangement? No
If YES, give effective date of lease. _____
- (9) Are you presently operating under a sublease agreement? _____ YES x NO
- (10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES _____ NO x If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over.

- (11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department of Public Aid during this cost report period. \$ 54,203
This amount is to be recorded on line 42 of Schedule V.
- (12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? No If YES, attach an explanation of the allocation.

SEE ACCOUNTANTS' COMPILATION REPORT

- (13) Have costs for all supplies and services which are of the type that can be billed to the Department of Public Aid, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? Yes
- (14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? Yes For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.
- (15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. \$ 18,900 Has any meal income been offset against related costs? Yes Indicate the amount. \$ 4,505
- (16) Travel and Transportation
a. Are there costs included for out-of-state travel? No
If YES, attach a complete explanation.
b. Do you have a separate contract with the Department to provide medical transportation for residents? No If YES, please indicate the amount of income earned from such a program during this reporting period. \$ _____
c. What percent of all travel expense relates to transportation of nurses and patients? 69
d. Have vehicle usage logs been maintained? Yes
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? Yes
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? N/A
g. Does the facility transport residents to and from day training? No
Indicate the amount of income earned from providing such transportation during this reporting period. \$ _____
- (17) Has an audit been performed by an independent certified public accounting firm? Yes
Firm Name: Smith Koelling Dykstra & Ohm, PC The instructions for the cost report require that a copy of this audit be included with the cost report. Has this copy been attached? Yes If no, please explain. _____
- (18) Have all costs which do not relate to the provision of long term care been adjusted out of Schedule V? Yes
- (19) If total legal fees are in excess of \$2500, have legal invoices and a summary of services performed been attached to this cost report? N/A
Attach invoices and a summary of services for all architect and appraisal fees.

Arthur Merkle Clara Knipprath Nursing Home

ID# 0021832

Report Period Beginning 1/1/03 Ending 12/31/03

Attachment to Schedule XX, Item 14

The portion of the building which is used for Independent Living Units is a completely separate section of the building with its own meters for utilities. Expenses, including depreciation, which relate to the Independent Living Units, are maintained separately in the accounting records.

12/31/2003

Facility Name & ID Number

STATE OF ILLINOIS
 Arthur Merkle Clara Knipprath Nursing Home 0021832
 Diagnostic Report

DIFFERENCE

Salary/Wages	Page 4, Line 45, Col 1	1,508,584		
	Page 20, Line 34, Col 3	1,508,584		0
Book Depreciation	Page 4, Line 30, Col 4	214,780		
Care Related Depr	Page 13, Line 82	124,877		
Non-Care Depr	PAGE 13, LINE 91, COL 3	89,903	214,780	0
Adjusted Depr	PAGE 4, LINE 30, COL 8	131,358		
	PAGE 13, LINE 83	131,358		0
Interest	PAGE 4, LINE 32, COL 3	0		
	PAGE 9, LINE 15, COL 10	0		0
Adjustments	PAGE 4, LINE 45, COL 7	(206,212)		
	PAGE 5, LINE 30, COL 1	(206,212)		0
Administrative Salaries	PAGE 3, LINE 17, COL 4	75,000		
	PAGE 21, SCHED A	75,000		0
PROFESSIONAL SERVICES	PAGE 3, LINE 19, COL 4	19,166		
	PAGE 21, SCHED C	19,166		0
DUES & SUBSCRIPTIONS	PAGE 3, LINE 20, COL 8	4,543		
	PAGE 21, SCHED F	4,543		0
EMPLOYEE BENEFITS	PAGE 3, LINE 22, COL 8	362,116		
	PAGE 21, SCHED D	362,116		0
TRAVEL & SEMINAR	PAGE 3, LINE 24, COL 8	60		
	PAGE 21, SCHED G	60		0
DEPRECIATION-COST	PAGE 13, SCHED E, LINE 81	3,692,048		
	PAGE 11, SCHED A, LINE 3	57,000		
	PAGE 12, LINE 34, COL 4	3,099,643		
	PAGE 13, LINE 75, COL 1	448,461		
	PAGE 13, LINE 80, COL 4	86,944	3,692,048	0
DEPREC - CURRENT BK	PAGE 13, SCHED E, LINE 82	124,877		
	PAGE 12, LINE 34, COL 5	95,980		
	PAGE 13, LINE 75, COL 2	23,004		
	PAGE 13, LINE 80, COL 5	5,893	124,877	0
DEPREC - STRAIGHT LINE	PAGE 13, SCHED E, LINE 83	131,358		
	PAGE 12, LINE 34, COL 7	102,461		
	PAGE 13, LINE 75, COL 3	23,004		
	PAGE 13, LINE 80, COL 6	5,893	131,358	0
DEPREC - ADJUSTMENTS	PAGE 13, SCHED E, LINE 84	6,481		
	PAGE 12, LINE 34, COL 8	6,481		
	PAGE 13, LINE 75, COL 4	0		
	PAGE 13, LINE 80, COL 7	0	6,481	0
ACCUMULATED DEPR	PAGE 13, SCHED E, LINE 85	2,454,452		
	PAGE 12, LINE 34, COL 9	2,094,941		
	PAGE 13, LINE 75, COL 6	293,548		
	PAGE 13, LINE 80, COL 9	65,963	2,454,452	0
BALANCE SHEET	TOTAL ASSETS-PAGE 17, LINE 25	6,185,902		
	TOTAL LIAB-PAGE 17, LINE 48	6,185,902		0
EQUITY	TOTAL EQUITY, PAGE 17, LINE 47	6,066,127		
	ENDING EQUITY, PAGE 18, LINE 24	6,066,127		0